Salary Continuance Plan ~ Employer Statement

Date Received: 10/10/01

Laura Patrick
Employee Name

025-52-1378
Social Security Number

What type of Leave is the employee currently on:

____ Standard Leave

_X_ Family Medical Leave

____ Intermittent Leave

Does the employee have any available sick pay? ____Yes _X_ No

If yes, how many hours and for which days? —

Will the employee be using any vacation pay for the 3-day waiting period or beyond?

____ Yes _X_ No

If yes, how many hours and for which days? —

Have you notified Payroll of these hours? _X_ Yes ____ No

Will the employee be working any hours during this leave? ____ Yes _X_ No

If yes, how many hours and for which days? _____

Employee's date of hire: 8-1-94

Adjusted date of hire (if any): —

Percentage of basic weekly salary payable:

____ 0 to 5 years of service (67%)

_X_ 5 to 10 years of service (75%)

____ 10+ years of service (80%)

State Disability: ____ CA ____ NJ ____ NY

Is the employer seeking reimbursement for State Disability? ____ Yes _X_ No

****You must attach a copy of the State Disability Application****

Employer Representative

10/10/01
Date

Form last updated: 10-23-00

EXHIBIT
Patrick 5
SCD 11/25/05

New Form 5/25/01

Application for Salary Continuance—Salaried Employees

Name: LAURA E PATRICK

Work Location (Company name): JANSSON

Job Title: DESIGN DEVELOPMENT Social Security Number: 025 52 1578

Estimated Dates of Leave: 10-15 THRU 11-26

Reason for Leave: (check one)

1. Pregnancy/Childbirth____
2. Illness ✓
3. Injury____

When did you become unable to work? 10-15-2001

What was your last day worked? 10-12-2001

If requested leave is for reasons 2 or 3 above, please provide a brief description of the illness or injury: FERTILITY CYCLE WITH ADDITIONAL SURGICAL PROCEDURE MONITORING WITH DAILY LABWORK, EXAMS AND ULTRA SOUNDS

Did the injury or illness result from employment? Yes____ No ✓

If yes, are you receiving workers' compensation? Yes____ No____

Are you receiving any other form of disability compensation from your employer? Yes____ No ✓

Do you have sick days to use for any portion of your leave? Yes____ No ✓

If yes, how many days? _____ (This information will be verified by the Payroll Dept)

Do you wish to use vacation/personal days for any portion of the 3-day waiting period?

If yes, how many days? Personal _____ Vacation _____

Do you plan to work part time during any portion of your leave? If yes, please describe your anticipated schedule:_____

EMPLOYEE VERIFICATION: I certify that the information on this application is true and correct to the best of my knowledge. I acknowledge that I will be required to submit a physician's certification prior to becoming qualified for salary continuation benefits, and authorize my physician, insurer or hospital to disclose any information necessary regarding the condition requiring my leave.

Date: 10-10-2001 Signature of Employee: [signature]

Home telephone number of employee: 781-639-0902

Please return this form to your Supervisor

New Form 5/25/01

Physician's Certification – Salary Continuance Plan

The patient is responsible for the completion of this form without expense to the Company

Patient/Employee's Name: Laura Patrick

Social Security Number: 025-52-1978

If leave is due to maternity/childbirth:

Type of Delivery: _____

Date of Delivery: _____

Please state the period during which patient will be unable to work: _____

If leave is due to injury or illness:

1. Is the patient presently unable to work or do you anticipate the patient will be unable to work due to injury or illness? yes
2. Date patient became unable to work: _____
3. Please describe the medical facts which support your certification: Patient will need to be available for daily blood work and ultrasounds.
4. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's incapacity, if different): Patient will be unable to work from Oct 15, 2001 – Nov 24, 2001
5. If additional treatments will be required for the condition, please describe such treatments: _____

Printed or typed name of Health Care Provider: Mitchell S. Rein

Type of Practice: Reproductive medicine

Signature of Health Care Provider: _____ Date: _____

Address: 1 Hutchinson Drive Danvers MA 01923

Telephone Number: 978-777-1070

EMPLOYEE PLEASE NOTE: If the length of disability exceeds the reasonable length of time for the diagnosis given, we reserve the right to require another doctor's opinion. The doctor's statement must be received within 30 days from the date the condition necessitating the leave began, and if leave is requested for any reason other than maternity/childbirth, an updated doctor's statement is needed every 30 days.

Please mail completed form to:
Taylor Corporation
Benefits Department Attn: Cindy Ross
1725 Roe Crest Drive
North Mankato, MN 56003

THE NORTH SHORE
MEDICAL CENTER

Mitchell Rein, MD
Chief, Department of
Obstetrics/Gynecology
Director of Women's Services

Women's Health Center
of the North Shore
1 Hutchinson Drive
Danvers, MA 01923
Tel: 978 777-1070
Fax: 978 774-9635

Salem Hospital
Medical Office Building, Suite 316
79 Highland Avenue
Salem, MA 01970
Tel: 978 744-7668
Fax: 978 744-8126

October 5, 2001

Jansson
411 Waverly Oaks Rd
Waltham, MA 02154
Attn: Human Resources Dept.

To Whom It May Concern:

Laura Patrick has been under my care for infertility since September of 1999. Due to ongoing medical complications, her fertility treatment to date has been unsuccessful. The next fertility cycle will be more demanding on her physically due to an additional and more complicated surgical procedure.

Infertility can take a significant physical, emotional, and economic toll on those struggling to become pregnant. It is my recommendation that Laura take a medical leave for her next 6-week cycle, which begins on October 15, 2001.

Should you have any questions regarding this letter, please feel free to contact me at (978) 777-1070.

Sincerely,

Mitchell S. Rein, MD

MSR:gad